SEXUAL AND REPRODUCTIVE HEALTH FOR transgender & gender non-conforming people

GUIDELINES FOR HEALTH CARE WORKERS IN PRIMARY CARE

GENDER DYNAMIX

A BOOKSHELF ESSENTIAL

Featuring more than 20 original voices, all with a great deal to say about today's transgender experience, this illuminating collection of personal stories offers a brand-new tone for the literary world.

These unique stories are interspersed with discussion chapters, body maps, and archival material. The true accounts collected here touch upon many of the social issues that this marginalised group encounters and each explains the need to counter negative stereotypes, reduce discrimination, and provide accurate information on gender identity.

As the first South African collection of its kind, this narrative provides honest representations of transgender lives and offers a valuable insight for those who better want to understand transgender issues.

Available from GenderDynamiX for 140.00 ZAR
Email: info@genderdynamix.org.za

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Written by Dr Alex Müller for Gender DynamiX

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Dr Elma de Vries

Sibusiso Kheswa

He-Jin Kim

Chris/tine McLachlan

Dr Anita Radix

Charlie Takati

Liesl Theron

Alok Vaid-Menon

Dr Caroline Ward

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Transgender and gender non-conforming people experience high levels of stigma-driven discrimination.

INTRODUCTION

The associated social and economic stressors predispose them disproportionately to mental and physical illness. As a result, transgender and gender non-conforming people have been identified as one of the most at risk populations for HIV and TB by the South African Department of Health in the 2012-2016 National Strategic Plan for HIV and TB. Transgender and gender non-conforming people encounter further discrimination at health care facilities where the ignorance and prejudice of some health providers create a hostile environment of indignity and unequal access to health care.

Healthcare providers need to understand how stigma impacts health and how they can contribute to the battle against stigma as well as having some level of technical competence in handling primary care health problems of transgender clients.

Quality trans-sensitive primary health care is only part of a broader strategy to promote the health and wellbeing of transgender people. South Africa plans to reengineer its Primary Health Care system under the National Health Insurance. Trans-sensitive health promotion, disease prevention and disease treatment will thus be initiated and coordinated by primary care providers.

Health care for transgender and gender non-conforming people involves two fields: general medical care and care for specific transgender health issues. The former may include aspects of sexual health which can be managed at a primary level. Primary care health workers may also encounter clients seeking gender-affirming therapy or may be asked to assist clients requiring maintenance /monitoring of gender-affirming therapy. Primary care providers, however, do not have to be experts in transgender medicine to meet the health needs of most transgender patients.

Most health needs from transgender and gender non-conforming people are not directly linked to their transgender identity. However, being transgender can be a large barrier to accessing health

care. Primary health workers will encounter transgender people in the whole range of health services, from cancer prevention services to HIV treatment. It is important that all health workers know about transgender and gender non-conforming patients, and know about the health needs that are relevant for primary health care.

This manual is written for primary care providers – in public facilities, in private GP practices, or for people working in health-related NGOs. It is meant as a first source of information about trans-sensitive quality care and provides information on trans health issues that one might encounter on a primary care level. It aims to provide health care workers with the knowledge to:

- Provide trans-sensitive health services
- Know about stigma-related discrimination and its impact on the health of transgender and gender non-conforming people
- Counsel transgender and gender non-conforming people about their health needs and provide adequate advice and referral
- Treat basic health needs of transgender and gender non-conforming people
- Become competent health care providers for transgender and gender non-conforming people

In the absence of guidelines emanating from South Africa, the information in these guidelines are based on the recommendations by the World Professional Association for Transgender Health (WPATH) and guidelines issued by the Centre of Excellence for Transgender Health (University of San Francisco, USA). They have been adapted to take into account the realities of transgender and gender non-conforming people in South Africa, and address the issues that Gender DynamiX's recent report on SA transgender access to health care has highlighted. Where suitable, the guidelines have quotes from South African transgender and gender non-conforming people to highlight their realities. These are meant to encourage health care workers to provide better services for trans people.

All guidelines that have been reviewed to compile this information are listed at the end of this manual. Where possible, a website is listed to access them online. All recommendations and guidelines presented in this manual should be read together with the current SA guidelines issued by the Department of Health, where appropriate. For example, this manual will not give specific advice on antiretroviral treatment choices, as these should be prescribed in accordance with the National ART Guidelines as issued by the Department of Health (or Provincial Department of Health where applicable).

TRANSGENDER AND GENDER NON-CONFORMING PEOPLE

In these guidelines, transgender and gender non-conforming includes any person who:

(a) Has a gender identity that is different from the sex at birth.

(b) Expresses gender in ways that contravene what society expects from a man or from a woman. This umbrella term includes cross-dressers, drag kings/queens, transsexuals, people who are androgynous, as well as people who do not identify with any labels (genderqueer people).

Sex is commonly understood as the classification of a person as male or female at birth, based on bodily characteristics such as chromosomes, hormones, internal reproductive organs, and genitalia.

Gender identity is one's basic sense of being male or female or another gender. It usually, but not always, matches the sex based on the external genitalia present at birth.

Gender expression describes aspects of a person's physical appearance, personality and behaviour which is defined culturally or socially to be either male or female. In other words, every society has its own assumptions about how biological women and men should feel, dress, act and work.

Transgender describes a person whose gender identity is different from the sex assigned at birth. A transgender person may choose to adhere to the gender role with which that person identifies. A person who does not adhere to gender roles is called gender non-conforming. It is important to recognise that the gender binary (the view that they are either male or female) does not describe the identity of many people.

Transwomen are born in a male body, but identify as female. Another term used to describe them is "Male-to-Female", or MtF.

Transmen are born in a female body, but identify as male. Another term used to describe them is "Female-to-Male", or FtM.

Sexual orientation describes who you are intimately attracted to. People are attracted to members of the same sex, of the opposite sex, or both. Western society tends to think of sexual orientation as expressing itself in three forms: homosexual (gay or lesbian), heterosexual (sometimes referred to as 'straight') or bisexual (having both homosexual and heterosexual feelings). People also identify as queer (refusing to fit into any category) and asexual (not being sexually attracted to people).

Heterosexual people are emotionally, physically and sexually attracted to people of the opposite sex.

Homosexual people are emotionally, physically and sexually attracted to people of the same sex.

Bisexual people are emotionally, physically and sexually attracted to people of both sexes.

Sexual orientation is not the same as gender identity. For example, a transwoman can be attracted to woman (and identify as a lesbian), to men (and identify as straight), or to both sexes (and identify as bisexual).

Experience with transphobia and discrimination in the health care setting, lack of access to health care workers who know about trans people's health needs, and (for some) discomfort with the body can lead transgender and gender non-conforming patients to avoid health care facilities altogether.

"I do go for HIV tests and they regularly tell me that I can't get HIV because I date a woman and we both have vaginas. They are also making jokes about my gender identity and sexual preference."

Transgender and gender non-conforming patients are a medically underserved population.

Transgender identity and behaviour is socially stigmatized, and many transgender individuals maintain a traditional gender role while keeping their transgender issues closeted

Health care for transgender and gender non-conforming people

In South Africa, transgender and gender non-conforming people often experience discrimination when accessing health care services. A recent study with 80 transgender and gender non-conforming people highlights that access to health care, especially to HIV care, is a major concern (Gender DynamiX 2012). It suggests that currently health services are discriminatory and health workers provide sub-standard care to transgender and gender non-conforming persons. Throughout this manual, we will use quotes from the report to highlight how transgender and gender non-conforming people currently experience the health care system. This is not to point fingers – rather, we hope that it will inspire health care workers to provide inclusive and non-judgmental care.

Stigma and abusive behaviour are important barriers to transgender persons accessing health care including HIV testing and ARV treatment. Health workers have disregarded the law and constitutional provisions and often suggested that transgender persons are illegal. The following quotes from participants in the study highlight this judgmental behaviour:

"They treat us like we are not human and they tell us all about God and what we did"

"They look at me like I am an alien and call me 'istabane' and want to know why I am like this"

"Yes I tested for HIV and was not of the best as the person who pricked me urged me to change my life as I being like I am is immoral she said"

As a result, transgender and gender non-conforming people wait too long to seek health care, or don't seek care at all.

> ***"I only go to the chemist to get something for me. I do not go to the clinics and I do not like them. I just feel that you do not get the right treatment that I deserve"***

This abusive and unprofessional behaviour is in direct contradiction to transgender and gender non-conforming people's status as a most at risk population under the current National Strategic Plan for HIV and TB, published by the National Department of Health in 2012.

While most transgender and gender non-conforming people have a basic knowledge of *HIV transmission and risk*, male condoms are often the only available prevention method. Some transgender persons practice safer sex, but unsafe sex is still common. Transmen need more understanding and information regarding the risk of vagina to vagina sex and how to protect themselves. Dental dams, female condoms and finger cots are not well known and not available. They are also not generally used given limited understanding of 'vagina to vagina' vulnerability.

> ***"I do not use prevention methods, I do not want to use them, it is only for men, not for women having sex with women"***

Transgender and gender non-conforming people are one of the major groups at risk for HIV infection.

Especially in South Africa, where the HIV epidemic is the largest in the world, transgender and gender non-conforming people need to have access to respectful, good quality health care services.

Violence and rape are reported, but health services do not address the particular needs of transgender and gender non-conforming people.

Transactional sex, often used as part of transgender people's ability to be resilient in the context of poverty, occurs quite frequently. The study also highlights the high rate of unemployment among transgender and gender non-conforming people, even though a large proportion of the study's participants had access to some form of tertiary education.

Alcohol and substance abuse, which is often linked to unprotected sex and other vulnerabilities, takes place on a significant scale. Specific interventions are required.

In summary, Gender DynamiX's report highlights the need to provide *services free from discrimination and stigma*.

It recommends that health care workers receive training and education to provide services in an affirming way which welcomes transgender clients.

Health care workers cannot generalise about transgender sexuality and gender identity in terms of sexual practice.

There is a wide continuum and diversity in practice and behaviours. Language used to express one's identity and sexual practice is also variable and assumptions should not be made regarding sexual practices.

Section 27 of the constitution states clearly that:

"Everyone has the right to have access to health care services, including sexual and reproductive health care".

Section 9 of the constitution (also called the Equality Clause) highlights that:

"The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth".

Denying a person health care, or treating a person differently because of their gender identity or sexual orientation is against the South African constitution.

The legal framewotk: health care for transgender and gender non-conforming people

The *Health Professions Council of South Africa* elaborates on the consequences of these constitutional obligations and binds health care workers in South Africa to its ethical principles in the code of conduct (excerpt from HPCSA General Ethical Guidelines for the Health Care Professions 2008). It requires every health care worker to:

- Respect patients as persons, and acknowledge their intrinsic worth, dignity and sense of value
- Recognise the human rights of all individuals
- Honour the right of patients to self-determination or to make their own informed choices, and to live their lives by their own beliefs, values and preferences
- Treat personal or private information as confidential in professional relationships with patients
- Be sensitive to, and empathise with, the individual and social needs of their patients
- Respect the rights of patients to have different ethical beliefs
- Treat all individuals in an impartial, fair and just manner

"Yes I did test for HIV. They asked me if I enjoy having sex with men. They told me having a male body and having sex with a man is against the law. I felt that they discriminated against me. I am HIV positive"

COMMUNICATION WITH YOUR PATIENT

Ask your transgender or gender non-conforming patient which pronoun they prefer, and stick to it. Correct other people if you hear them using the incorrect pronoun.

"They write on the card male or female and laugh out in my face. They are also the ones who prejudice other patients to mock me"

"I tested at a public clinic and people were quite interested in my life story. I did not experience discrimination but there were some staff who I could sense were skinnering (gossiping) about me"

Open communication usually happens within a relationship of trust and respect. This may take some time to grow. For this reason it is important for health care workers to be prepared to build relationships with transgender and gender non-conforming patients.

General skills

Like all patients, your trans-gender and gender non-conforming patients need a setting of respect and trust to talk about their health issues. Below are guidelines to establish trust and to treat transgender and gender non-conforming patients respectfully.

"I was treated very well as a woman until they need[ed] to fill in on the pills that I [was] born as a man because it...cause[d] problems with the medical aid [because] I...[have] to explain that I am transgender. The fact that they have to write my birth gender on the forms is very painful and annoying for me and makes me embarrassed"

Speak to your patient in private. Assure them that you will treat what they say as confidential and do so.

Don't assume that everything will be dealt with after one interaction. Be truthful to your patient if you are still learning about trans issues. Most trans people will find it comforting that you are respecting them and that you are learning how to be in a professional relationship with them.

It is always important to introduce yourself properly and make sure that your patient understands exactly what they can expect from you.

Let them talk first. Don't be too quick to try and solve their problem. If they

are battling to express themselves reassure them that you will treat their information as confidential. Tell them to take their time.

If you do know that your patient is transgender or gender non-conforming, do not make assumptions about their personality or lifestyle.

Don't probe into your patient's private life. This is not your opportunity to get sensational information about the kind of sex transgender people have.

When speaking to patients, you often cannot tell whether someone is homosexual, heterosexual or bisexual. They will not necessarily tell you. For this reason, do not assume that your patient's partner is of the opposite sex. Instead of referring to specific relationship roles like 'wife' or 'boyfriend', use the word 'partner'.

Don't make assumptions about the reproductive wishes and choices of your patients. Just because a transgender person does not conform to stereotypical female gender roles does not mean they don't want to become pregnant.

Find out what support structures your patients have available. If they have no reliable support, refer them to organisations like Gender DynamiX, SHE or TIA. You will find contact information at the end of this booklet.

If you are unsure about anything, ask your patient rather than assume.

Help your patient to become aware of their rights. Just because they seem confident in the way they speak doesn't mean that they are empowered.

Treat your patient the same way as you treat all gender conforming patients – we are all human beings.

PHYSICAL EXAMS

Physical exams are relevant to the anatomy that is present, rather than the perceived gender of the patient, or the patient's affirmed gender. Socially, always refer to and treat your patient as their preferred gender. For example, if breast tissue is present, do routine breast exams, but if your patient identifies as male, relate to him as a man and use male pronouns. Always address a patient who identifies as a man with 'he' and his preferred name, even if you are doing a vaginal exam; always address a patient who identifies as a woman with 'she' and her preferred name, even if you are doing a prostate exam. Some transgender patients may not be comfortable with their bodies, and they may find some elements of a physical exam traumatic. If you have to do a physical exam, explain in detail what you are going to do, and explain to your patient when, why and how you need to touch them.

Several HIV prevalence studies conducted in the United States, Europe and Asia report high rates of HIV infection among MTF (male-to-female) transgender persons. Studies have found that lower income transgender people are even more vulnerable.

These studies have argued that efforts to prevent the spread of HIV/AIDS among the transgender community are urgently needed and that these efforts must be specifically targeted toward transgender people, including FTM (female-to-male) transgender people. Even the most vulnerable transgender populations, including transgender sex workers, could benefit from targeted HIV prevention interventions, HIV testing, and interventions to help reduce the risk of contracting or transmitting HIV.

HIV care for transgender and gender non-conforming people follows the same principles and guidelines as for everybody else. It is important to note specific vulnerabilities for transgender and gender non-conforming people though, because these need to be addressed in prevention efforts and treatment programmes. It is also important to note that some transgender people have different anatomies in their genitals, which can change the way that STIs or other conditions present. If you are in doubt, refer your patient to a specialist service.

HIV PREVENTION

In HIV prevention, it is necessary to account for the fact that the sexual practices of transgender and gender non-conforming people often do not follow the heterosexual practices that HIV prevention programmes are aimed at. The table opposite provides an overview of sexual practices, HIV risk and prevention possibilities.

Judging from studies conducted across the world, we can assume that transgender people in South Africa are particularly susceptible to HIV infection.

HIV TESTING

Transgender and gender non-conforming people have been identified as one of the 'most at risk populations' in the current Strategic Plan for HIV/AIDS and TB. This means that all health care workers who work in HIV programmes and STI clinics should provide services for them. Transgender and gender non-conforming people have the same rights to access treatment and prevention as everybody else.

Transgender and gender non-conforming people should receive HIV testing services that are

- voluntary and fully consenting
- confidential and/or anonymous
- non-judgmental
- preceded by adequate counselling

SEXUAL PRACTICE	HIV AND STI RISK	PREVENTION METHODS
Penetrative sex (in anus or vagina)	High for HIV High for STIs	Use male condoms (penis) Use female condoms (vagina)
Oral sex	Medium-low for HIV Medium-low for STIs (herpes, gonorrhea, chlamydia)	Use condoms (for penises) Use dental dams, or non-microwaveable cling wrap (for vaginas)
Fingering and handjobs	Low for HIV Low for STIs	Wash hands, no cuts on hands, use gloves
Rimming (licking or sucking the anus)	Low for HIV High for some STIs	Wash area, use dental dams or non-microwaveable cling wrap *(NB: high risk for some STIs)*
Scissoring (rubbing genital areas against each other)	Low for HIV Low for STIs	Wear underwear Use non-microwaveable cling wrap
Fisting (insert whole hand into vagina or anus	Low for HIV Low for STIs Risk for injuries	Use gloves Use lubricant

that takes sexual practices outside of the purely heterosexual teaching into account (see table above)

- followed by counselling about safer sex (regardless if testing negative or positive) and a referral to HIV follow up care (if testing positive)

ARV TREATMENT

Transgender and gender non-conforming people have the same right to access and receive antiretroviral and supporting treatment as anybody else. All HIV monitoring should be done in accordance with the current national ARV guidelines. Once a transgender or gender non-conforming person qualifies for ARVs, they should receive adherence counselling and be started on treat-ment as soon as possible. Being transgender, gender non-conforming, or taking hormone treatment is NOT a contraindication for ARV treatment! Some transgender patients take hormones without a prescription.

To reduce possible interactions with HIV-related treatment, you should inquire about patients' use of non-prescribed hormones and should ask for specific information regarding the type of hormones patients are obtaining.

For more information, see the chapter on cross-gender hormone replacement treatment.

For adherence counselling, keep in mind that transgender and gender non-conforming people often live under additional social stress due to transphobia, homophobia and stigma.

Work with your patient around issues of disclosure, and keep in mind that often their friends replace family.

Counsel your transgender and gender non-conforming patients about safer sex. The table above gives you basic information. Gender DynamiX has also published a booklet on safer sex for trans people. You can obtain it at their offices, or refer your patients to them.

Mental health & Substance use

Being a transgender or gender non-conforming person does not, in itself, constitute a pathological condition of any kind.

MENTAL HEALTH

Living as a trans person often requires efforts to cope with discriminating and hostile environments.

Previously, transgender and gender non-conforming people were mentioned in the Diagnostic and Statistical Manual of Mental Disorders under the category of 'gender identity disorder' (DSM-IV TR). This is currently under revision and it is anticipated that it will be replaced with 'gender dysphoria'. This refers to the lack of agreement between a person's natal sex characteristics and her or his gender identity and can be a source of serious psychological distress.

Both hostile environments and gender dysphoria can have a strong negative impact on the emotional and mental health of transgender and gender non-conforming people throughout their lives. Mental health is the number one health concern among transgender and gender non-conforming people (IOM, 2011). Anxiety and depression are widespread among trans people and as many as 40% have, at one point in their lives, attempted suicide (Grant et al. 2010). The experience of having to live in secrecy and isolation can be a strong cause of anxiety and depression.

For many persons, the fear of not being able to have a partner and to enjoy a loving relationship can be overwhelming.

As with all patients, you should ask about psychiatric illnesses, including substance abuse. Specifically, you should keep in mind the following mental health issues:

- **Depression**: Ask about symptoms of depression (depressed mood, problems with sleeping, weight gain or loss, thoughts about suicide) and refer to mental health services if necessary.
- **Anxiety disorders and post-traumatic stress disorder:** Trans people may have suffered harassment or physical trauma. Patients who have experienced trauma should be asked about symptoms of post-traumatic stress disorder, as well as other anxiety disorders. If a patient reports sexual violence or domestic violence to you, refer to the chapter on sexual assault and domestic violence of this manual for further guidance.
- **Substance use** may occur as avoidance coping in patients with gender dysphoria or stressful environments. Referral for psychiatric illness and substance abuse treatment should be to a mental health provider with an understanding of trans care issues.

SUBSTANCE USE

We know very little about the extent and intensity of alcohol and other substance use among transgender and gender non-conforming people in South Africa.

A recent study of health risk behaviours of South African trans people suggests that levels of substance abuse are high (Gender DynamiX 2012). This is in line with international literature, and is often due to the levels of social stigma, social exclusion and transphobia that transgender and gender non-conforming people experience.

When you have a transgender or gender non-conforming patient, keep in mind that they might have issues of substance abuse. Actively ask about it, and know about possibilities if they need support.

SUBSTANCES TO KEEP IN MIND

Nicotine

We know that sexual minorities in general have higher levels of smoking. All associated health risks are therefore increased (lung disease, cancer, etc.) Transwomen who take hormone therapy (oestrogens) will have a higher risk of developing blood clots and embolic disease if they smoke, so you should tell them about the risk.

Alcohol

Similar to nicotine, sexual and gender minorities also have higher levels of alcohol consumption. In addition to increased health risks related to alcohol, also keep this in mind when counseling about safer sex. Safer sex often gets compromised when people are under the influence.

Marijuana, tik, cocaine and other illegal drugs

There is no statistical evidence of the use of these drugs in transgender and gender non-conforming patients, but anecdotal evidence suggests that they are being used by some.

The most important principle to apply in general prevention and screening is to provide care for the anatomy that is present, regardless of the patient's gender identity, presenting gender, or legal status — and always to provide that care in a sensitive, respectful, and affirming manner that recognizes and honours the patient's self-description or identification.

Prevention and health promotion

Most medical problems that arise in transgender patients are unrelated to gender-affirming therapies.

The following areas of prevention are important for primary health care workers:

CANCER

Transgender and gender non-conforming people should receive the same cancer screening as people of their natal sex as long as the organs are present, i.e., not removed during gender confirmation (sex reassignment) surgery.

Transmen

Transmen should have the following screenings:

- Breast cancer: follow the recommendations for natal females, including mammography
- Cervical cancer: follow the recommendations for natal females, including pap smears if indicated

Transwomen

Transwomen should have the following screenings:

- Prostate cancer: Follow the recommendations for natal males. Use a digital rectal exam to evaluate the prostate in all transwomen. Prostate specific antigen levels may be falsely low in transwomen who are receiving anti-androgens.

HIV prevention programmes are aimed at. The table on page 7 provides an overview of sexual practices, HIV risk and prevention possibilities.

HIV

HIV counselling should take into account trans-specific risk factors and cofactors. In addition to sexual risk behaviours of unprotected anal/vaginal intercourse (including receptive vaginal intercourse for trans men and insertive anal intercourse for trans women), trans individuals may be at risk through sharing injection needles during drug, hormone, and soft tissue filler injections. Sometimes hormone use can result in mood swings, testosterone increases the libido and decreases control over sex, and oestrogens may impair erections, making condom use more difficult. Some

transgender and gender non-conforming people do sex work to earn an income. Sex workers are at a higher risk for HIV, particularly when clients offer more money for unprotected sex. When counselling transgender and gender non-conforming people about safer sex, refer to the table in the chapter on HIV. Comprehensive HIV prevention includes male and female condoms and potentially dental dams or material that can be used when dental dams are not available.

Trans women and men may be at a higher risk for HIV when they feel that they are not in a position to negotiate safer sex for the fear of losing a partner. This is particularly important because many trans people have made experiences of partners or potential partners rejecting them for being transgender or gender non-conforming.

SEXUALLY TRANSMITTED INFECTIONS

Some sexually transmitted infections might look different in transgender people who have had genital surgery or are taking hormones. If you are in doubt about the presentation of symptoms or about poor response to therapy, refer your transgender patient to a specialist service (*see resources at the end of this manual*).

GENITAL TAPING OR TUCKING

Some patients may attempt to hide their genitals by taping or tucking. Taping increases the risk for urinary tract infections, as well as sores and damaged tissue. This risk is even increased when patients use material that easily can tear skin, for example duct tape. Health care workers should examine the genital area and provide early treatment

for issues such as balanitis, candidiasis and other soft issues infections. Patients should be advised to pay attention to hygiene and not apply adhesive tape directly to the genitals. If patients use tape, they should use surgical/ medical tape, and not duck tape.

If you suspect that a patient may be at risk for intentionally harming their genitals, then refer to a mental health specialist of a specialist transgender service.

Tucking refers to transgender people with a male body who attempt to tuck their testicles back into the inguinal canal. This can increase the risk of inguinal hernia.

BINDING

Transmen might bind their breast to have a flatter chest. The health risks associated with binding are skin irritations, bruises, rib fractures (if too tight) and, especially in young transmen, binding can potentially impact lung and rib development. It is therefore important to use material that does not cause skin irritation (for example, no use of duck tape). Transmen should not bind for more than 8-12 hours a day.

Transgender and gender non-conforming people may or may not wish to alter their physical appearance. There are a number of options to change the body in a way that makes it appear more like the person's gender identity. These options range from taking hormones to more invasive procedures.

Gender-affirming treatment

Transgender and gender non-conforming people may or may not wish to alter their physical appearance.

While previously, a person wishing to have gender-affirming treatment needed to undergo a lengthy evaluation from psychologists or psychiatrists, the new Standard of Care guidelines (SOC-7) published by the World Professional Association for Transgender Health (WPATH) state that a person wishing to have hormone treatment only needs a referral from a mental health professional. A person wishing to have gender-affirming surgery should have referrals from two mental health professionals.

In South Africa, it is legal to change one's body's sexual characteristics. Once a person has undergone hormone treatment or surgery, they can apply to receive official identification (ID and passport) in their identified gender. This application needs certificates from two medical practitioners: from the practitioner who carried out the gender-affirming treatment, and from another practitioner to confirm the person's identified gender (Act no. 49 of 2003: Alteration of Sex Description and Sex Status Act).

Access to specific health care such as specialized counselling, psychotherapy, hormone therapy, and/or surgery, is severely limited, yet crucial for the well-being of transgender and gender non-conforming people.

The World Professional Association for Transgender Health maintains an international directory of specialized providers (see resources section of this manual). However, certain aspects of specific care such as hormone therapy can also be provided in the primary care setting. All care should be offered in accordance with the WPATH's Standards of Care (WPATH SOC-7, see resource section).

Not all transgender patients will want to take cross-sex hormones, but if a transgender patient does need to express a gender different from their assigned birth sex on a consistent basis, cross-sex hormones are the most common body modification that transgender patients can access for self-actualization, bringing the endocrine and psychological systems into balance.

The extent to which you as primary care provider need to know about gender affirming therapies will vary according

to your professional role and health care setting:

- You may be asked by a client for a referral to obtain such therapy and need to know about the available referral networks and resources.
- You may see a client who is already on therapy. You would now need to understand how a transgender body may be different /unusual and how that can affect health and health care. This includes an awareness of its relevance to sexual health and the effects of hormone therapy.
- Primary care providers may be part of a clinical team providing gender affirming therapy. You may, for example, be asked by a specialist to continue prescribing hormone therapy and/or to monitor a transgender client
- A transgender person may ask to be started on hormone therapy. With suitable skills, and/or in consultation with a transgender specialist it is possible for a primary care provider to initiate therapy. Gender affirming therapeutic guidelines must then be followed.

CROSS GENDER HORMONE TREATMENT (CGHT)

The aim of hormone treatment is to make a transgender person's body more similar to their gender identity.

Preparations and administration

Transwomen (male-to-female, MtF) need to take oestrogens (a hormone that has high levels in biologically female bodies) as well as anti-androgens (drugs that limit the effect of the hormones of biologically male bodies). Oestrogen aministration can be oral, transdermal, intramuscular, or by implant.

Transmen (female-to-male, FtM) need to take testosterone. Testosterone can be given as an injection or as a patch (like a plaster with testosterone that enters the body through the skin). If you prescribe injectable hormones to a patient, you must ensure that they know about safe injection techniques. Patients should be taught to self-inject, including how to keep equipment sterile. A family member or friend may be taught to perform the injection for the patient.

Physical changes

In transmen (female-to-male patients), hormone treatment changes the body in the following ways: the voice deepens, the clitoris gets larger (how large is different from person to person – it will reach a size between 2 to 5cm), the person grows facial and body hair, the monthly periods become irregular and eventually stop, breasts will become smaller, and the body develops more muscles and less fat. Table 1A on the next page shows an overview of all changes and the time period within which they occur (*taken from WPATH SOC-7 Guidelines, p.37*).

In transwomen (male-to-female patients), hormone treatment changes the body in the following ways: breasts will grow (how big is different from person to person), the person is less likely to have erections, the testicles will become smaller, and the body develops more fat and less muscles. Table 1B on the next page shows an overview of all changes and the time period within which they occur (*taken from WPATH SOC-7 Guidelines, p.38*).

Most changes are completed after 2 years. How much a body changes, and when exactly the changes happen is different for every person. Hormones must be taken life-long.

TABLE 1A: EFFECTS AND EXPECTED TIME COURSE OF MASCULINISING HORMONES[A]

EFFECT	EXPECTED ONSET[B]	EXPECTED MAXIMUM EFFECT[B]
Skin oiliness/acne	1 - 6 months	1 - 2 years
Facial/body hair growth	3 - 6 months	3 - 5 years
Scalp hair loss	>12 months[C]	variable
Increased muscle mass/ strength	6 - 12 months	2 - 5 years[D]
Body fat redistribution	3 - 6 months	2 - 5 years
Cessation of menses	2 - 6 months	n/a
Clitoral enlargement	3 - 6 months	1 - 2 years
Vaginal atrophy	3 - 6 months	1 - 2 years
Deepened voice	3 - 12 months	1 - 2 years

TABLE 1B: EFFECTS AND EXPECTED TIME COURSE OF FEMINISING HORMONES[A]

EFFECT	EXPECTED ONSET[B]	EXPECTED MAXIMUM EFFECT[B]
Body fat redistribution	3 - 6 months	2 - 5 years
Decreased muscle mass/ strength	3 - 6 months	1 - 2 years[C]
Softening of skin/ decreased oiliness	3 - 6 months	unknown
Decreased libido	1 - 3 months	1 - 2 years
Decreased spontaneous erections	1 - 3 months	3 - 6 months
Male sexual dysfunction	variable	variable
Breast growth	3 - 6 months	3 - 3 years
Decreased testicular volume	3 - 6 months	2 - 3 years
Decreased sperm production	variable	variable
Thinning and slowed growth of body and facial hair	6 - 12 months	>3 years[D]
Male pattern baldness	No regrowth, loss stops 1 - 3 months	1 - 2 years

Accessing hormones

Currently, there are no local guidelines for primary care health workers to prescribe hormones. Usually, hormone treatment is initiated by specialists – either at the Groote Schuur Hospital transgender service in Cape Town, or through private endocrine specialists. Gender DynamiX has a list of providers who provide hormone treatment, and to whom you can refer a patient seeking hormone treatment. HIV positive people can receive hormone treatment.

No transgender or gender non-conforming person may be denied access to hormone therapy because they are HIV positive, or have another infectious disease (WPATH SOC-7, page 35). Transgender people who take hormone treatment can still take antiretroviral treatment for HIV. There are no studies yet about the drug interactions between ARVs and doses of hormones commonly used in CGHT. However there are data on interactions between ARVs and oral contraceptives, most often ethinyl estradiol. Table 2 shows these. This does not mean that transgender patients who take hormone therapy cannot take ARVs – it only means that some ARV combinations should be avoided. There are no interactions between hormones and the nucleoside/nucleotide reverse transcriptase inhibitors (NRTIs) such as Zidovudine, Lamivudine and Tenofovir, however interactions may occur with non-nucleoside reverse transcriptase inhibitors (NNRTIs) and protease inhibitors (PIs).

Risks of hormone therapy

Risk depends on many factors: the medication itself, the way it is administered, and characteristics of the patient (for example age, other illnesses, family history, and lifestyle). Table 3 presents the most important risks that might be encountered and managed by primary care health workers.

TABLE 2: ARV CLASSES AND EFFECTS ON ESTRADIOL

ANTIRETROVIRAL CLASS	OBSERVED DRUGS IN CLASS	OBSERVED IMPACT ON PHARMACOKINETICS OF CO-ADMINISTERED ETHINYL ESTRADIOL
Ritonavir Boosted PIs	Lopinavir/ritonavir (Kaletra) Fosamprenavir/ ritonavir Atazanavir/ritonavir Darunavir/ritonavir Tipranavir/ritonavir	Decreases ethinyl estradiol levels
Non boosted PIs (no ritonavir)	Atazanavir Fosamprenavir	Increases ethinyl estradiol levels
NNRTI	Nevirapine Etravirine Rilpivirine	Can show decreased or increased plasma concentrations of ethinyl estradiol estrogen or norethindrone. **Efavirenz does not affect ethinyl estradiol levels*

TABLE 3: RISKS OF HORMONE THERAPY LIKELY TO BE ENCOUNTERED BY PRIMARY CARE HEALTH WORKERS

RISK LEVEL	FEMINISING HORMONES	MASCULINISING HORMONES
Likely risk	Hypertriglyceridemia (elevated blood fats) Venous thromboembolic disease (blood clots)	Polycythemia (increased amount of blood cells) Acne Weight gain
Likely risk if other risk factors are present	Cardiovascular disease (for example heart attacks, stroke)	
Possible risk	Hypertension	Hyperlipidemia
Possible risk if other risk factors are present	Type 2 Diabetes	Hypertension Type 2 Diabetes Cardiovascular disease
NO increased risk (or inconclusive)	Breast cancer	Breast cancer Cervical cancer Ovarian cancer Uterine cancer

Transgender patients on hormone therapy need to monitor certain blood parameters.

BASELINE LABORATORY TESTS

Essentials for transwomen

- Fasting lipid panel (if on oral estrogen).
- Potassium and creatinine for those on Sprinololactone. Use female reference values for transwomen taking estrogens.
- Liver functions: Unless there is evidence of liver disease, there is no current clinical evidence for checking liver function in transwomen using estrogen. Current publications make no mention of liver function abnormalities in relation to estrogen use. However, it may be useful to check transaminases if the patient is taking oral estrogen.

Essentials for transmen

- Haemoglobin, LDL/HDL. Use male reference values for transmen taking testosterone.

Considerations with respect to laboratory tests: Family history, age, concomitant illnesses, sexual activity, other relevant risk factors.

In South Africa, many transgender and gender non-conforming people have very poor access to health care. For that reason, transgender people sometimes start self-medicating their hormone therapy. For example, transwomen may start taking oral contraceptives (the pill), which may elevate the risk for blood clots.

CGHT and reproduction

Hormone treatment may cause irreversible infertility, but the effects are unpredictable. The health provider who initiates therapy should discuss fertility issues with the client. Transmen and transwomen who have an intact reproductive system may still be able to

conceive while on CGHT and need to consider contraceptive options, e.g. barrier methods. A transman who has unprotected sex with a fertile cisgender man is at risk for pregnancy, HIV and STIs. Even though testosterone reduces fertility, it is not a contraceptive.

Hormone treatment may reduce fertility, and this can last even if hormones are discontinued. Estrogen can reduce a person's libido, erectile function, and ejaculation. Testosterone generally increases libido.

"Me and my partner are very cuddly. We do not have sex regularly. She has to be on top of me. Being on hormone treatment it is very difficult for me to get an erection and be sexually satisfied"

FOLLOW-UP CARE: Overview of the process for primary health care providers

Patients have ongoing psychosocial and primary care needs. Most medical problems that arise in transgender patients are not secondary to cross-sex hormone use.

Primary care providers may provide some of the necessary follow-up care if their patients have been referred from specialist services. In this case, it is important that primary care providers maintain close contact with the referring specialist.

If suitably skilled and/or supported by a gender specialist, a primary care provider can initiate cross-hormone therapy and monitoring.

Follow-up scheme for patients initiating hormones

Follow up medically at 4 weeks, 3 months, 6 months and every 6-12 months thereafter (more frequently if other problems arise). Check blood pressure, side effects, emotional changes, sexuality, weight, and inquire about any risk behaviour.

Consider giving calcium and vitamin D (similar to osteoporosis prevention) to female-to-male transitioning people.

First few follow-up visits: 4 weeks to 6 months

Assess for desired and adverse effects of medication. Check weight and blood pressure. Physical exam as needed. Discuss social adjustment, libido and sexual behaviour, quality of life and inquire about any risk behaviour.

- *Trans women:* If on spironolactone (an anti-androgen medication), check potassium.
- *Trans men:* Assess menstruation. Menstruation should stop within 2-3 months. If it persists, you might increase the testosterone, or give a progestogen, e.g medroxyprogesterone acetate (DMPA).

Half-yearly visit

Assess for desired and adverse effects of medication. Check weight and blood pressure. Review health maintenance. Provide directed physical exam as needed. Discuss social adjustment, libido and sexual behaviour, quality of life and inquire about any risk behaviour.

- *Trans women:* If spironolactone dose increased, check potassium again. Testosterone is generally not checked unless patients have little evidence of feminisation.

- *Trans men:* Check testosterone level if after 6 months on stable regimen patient only shows little physical changes or doesn't stop menstruating, or is has anxiety or other mood symptoms.

  For testosterone enanthate/cypionate injections, the testosterone level should be measured mid-way between injections. For parenteral testosterone undecanoate, testosterone should be measured just before the following injection. For transdermal testosterone, the testosterone level can be measured at any time after 1 week. Be sure to compare hemoglobin levels to age-appropriate male levels. Follow-up blood tests are done generally every 6-12 months (6 on older patients, patients with other serious illnesses, and 12 for young healthy patients).

Annual visit

Assess for desired and adverse effects of medication. Check blood pressure and weight. Review health maintenance. Provide directed physical exam as needed. Discuss social adjustment, libido and sexual behavior, quality of life and inquire about any risk behaviour.

Trans women: Prolactin screening once at 1-2 years after beginning hormone therapy.

- Breast cancer prevention according to standard guidelines.
- Prostate cancer prevention according to standard guidelines.

Trans men: Check testosterone level at 6 months or when on stable regimen, if virilisation is inadequate, or if patient does not or stop menstruating, or is experiencing anxiety. For guidelines on how to check testosterone levels, refer to information under 'half-yearly visit'. Be sure to compare hemoglobin levels to age-appropriate male levels.

- Breast cancer screening according to standard guidelines if there is detectable breast tissue.
- Gynaecological pelvic exam every 1-2 years.
- Pap smears according to standard guidelines.

The waiting list is very long (up to 25 years). As a result, some transgender people seek surgical care overseas if they can afford it. Gender DynamiX's recent study on access to health care has shown that gender-affirming surgery is not a concern for most transgender people living in South Africa.

In South Africa, access to gender-affirming surgery is very limited. Groote Schuur Hospital in Cape Town has a transgender health team and performs about 5 surgeries a year.

The realities of limited access, as well as other ways to perform the identified gender, make it a lesser priority than access to hormone treatment. Nevertheless, health care providers should know about the basics about gender-affirming surgery.

This section provides background information on the surgical procedures patients may be considering, or may have already undergone. Procedures should generally be conducted subsequent to an assessment of a patient's individual preparedness for the intervention in question. The WPATH *Standards of Care* include a list of recommended criteria for such assessments (WPATH SOC-7, Appendix C).

Primary health care providers should not discourage clients who seek gender-affirming surgery, but refer them to NGO's who can facilitate contact with such services (see contact information at the end of this manual).

For a transwomen, transitioning male-to-female (MtF), these surgeries are possible:

1. *Breast/chest surgery:* If breast growth stimulated by estrogen is insufficient (only progressing to the 'young adolescent' stage of breast development), augmentation mammoplasty may be indicated for adequate gender affirmation.

2. *Genital surgery:* removing the penis (penectomy) and the testicles (orchiectomy) and building a vagina (vaginoplasty).
   - Orchiectomy is the removal of the testes. Some trans women will have this procedure without a vaginoplasty or penectomy. Estrogen therapy may need to be adjusted post-orchiectomy; orchiectomy may permit lower doses of estrogen therapy and eliminates the need for testosterone blockers.
   - Vaginoplasty is the construction of a vagina to enable female sexual function using penile tissue or a colon graft. The procedure usually involves clitoro-labioplasty to create an erogenously sensitive clitoris and labia minora and majora from surrounding tissues and/or skin grafts, as well as a clitoral hood.

Colon grafts do not require dilation and are self-lubricating; however, the lubrication is present at all times and may become bothersome. Additionally, colon grafts must be screened for colon cancer and should be monitored by the surgical team if the patient develops inflammatory bowel disease.

— Penectomy is the removal of the penis. This procedure is not commonly done. Generally, penis removal is done in concert with vaginoplasty. In some surgical techniques, the penile skin is used to form the vagina, so this is not a straightforward amputation, but a potentially complex procedure intended to utilize analogous tissue as well as maintain nerve function to preserve sexual responsiveness.

For a transman, transitioning female-to-male (FtM), these surgeries are possible:

1. *Breast/chest surgery:* remove breasts (subcutaneous mastectomy), and create a male chest. Chest reconstruction is the procedure most frequently required by transmen. A variety of techniques may be used, depending on the amount of the patient's breast tissue. One of the complications is scarring, and nipples may be large or small and grafted, depending on the surgeon's technique.
2. *Genital surgery:* remove uterus and ovaries (hysterectomy/ovariectomy), building of a penis from the clitoris (metoidioplasty) or from other skin (phalloplasty), building of testicles (scrotoplasty), and implanting erection and/or testicular prostheses.

— Metoidioplasty is the construction of male-appearing genitalia employing the testosterone-enlarged clitoris as the erectile phallus. The phallus generally will be small and has the appearance of an adolescent penis, but erectile tissue and sensation are preserved. This procedure releases the clitoral hood, sometimes releasing the suspension ligaments to increase organ length, may involve raising the position of the organ a centimeter or so toward the anterior, and may include scrotoplasty and (less frequently) urethroplasty. Closure of the vaginal opening may be full or partial, or the vaginal opening may not be impacted at all, depending on the surgeon's technique. This procedure is much less invasive than a phalloplasty procedure, and emphasizes preservation of erotic sensation.

— Phalloplasty is the construction of a phallus that more closely approximates the size of an erect male organ, using tissue from another part of the patient's body. Size and appearance are prioritized over erectile capacity, and in some cases over erotic sensation. Skin flaps used in this procedure include abdominal flap (no erotic sensation), radial forearm flap, deltoid flap, and calf flap (all of which contain nerves that may be grafted to the pudendal nerve to provide erotic sensation). Erectile capacity is provided via implanted semi-rigid or inflatable penile prostheses.

— Scrotoplasty is the construction of a scrotum, usually using labia majora tissue and saline or silicone testicular implants. Some surgeons will use tissue expanders and place the implants after the tissue has been stretched sufficiently to accommodate the implants. This procedure is rarely done separately, but is usually performed in conjunction with either

a metoidioplasty or a phalloplasty procedure, and with some phalloplasty/urethral extension techniques, it may be necessary to perform the scrotoplasty as a later stage, after urethral healing.

– Urethroplasty is the creation of the urethral canal through the neophallus to facilitate standing micturation. This is usually, but not always, done in conjunction with genital reconstruction. Some trans men will avoid this procedure due to the potential for complications, or their genital plastic surgeon may not be willing or able to perform this procedure, either as a matter of general practice, or specific to the patient's body habitus.

In order to undergo chest/ breast surgery, the WPATH guidelines specify that a patient needs a referral letter from a mental health professional (WPATH SOC-7, page 59). South Africa follows the WPATH guidelines. For genital surgery, a patients needs referral letters from two mental health professionals (WPATH SOC-7, page 60). For all genital surgery patients should have had at least 12 months hormone treatment before the surgery. For some FtM surgery (phalloplasty and metoidioplasty) and some MtF surgery (vaginoplasty) patients may also need to show that they have lived in their identified gender for at least 12 months. This needs to be documented by the mental health professional who writes the referral.

No transgender or gender non-conforming person may be denied access to gender-affirming surgery because they are HIV positive, or have another infectious disease (WPATH SOC-7, page 56). It is important to know that like all surgical procedures, the surgeries outlined above can have complications.

POST-SURGICAL FOLLOW-UP

Transwomen

Examine for difficulties in healing. After pedicled penile flap technique vaginoplasty, the patient must dilate 3-4 times daily, per surgeon's recommendations, using progressively larger dilators. After the initial 6-12 month period, if the patient is having regular sexual intercourse, no further dilation is required. Otherwise, continue routine dilation once or twice per week. Transwomen will need to use lubrication to have sex.

Post-operative complications may include bleeding, infection, or impaired wound healing. Possible late complications include stenosis of the new urethral meatus. Refer to a surgeon with expertise.

Neovaginas don't need pap smears. Inspect the neovagina with a speculum, look for genital warts, erosions, and other lesions.

Transmen

Examine for difficulties in healing. Complications in chest reconstruction may include hematoma, partial or total nipple necrosis, and abscess formation. Drains and compression bandages do not always prevent these complications. Keloid scarring may occur, particularly in people of color. In some instances, scarring may be lessened by ensuring that incisions are not stretched prematurely during healing. Complications of genital reconstruction include implant extrusion; urethral fistulas and strictures, loss of sensation and tissue necrosis in the neophallus created by phalloplasty (not generally a problem with metoidioplasty).

Transgender and gender non-conforming people have the same rights as everybody else. The Sexual Offenses Act of 2007 defines rape as an act of Sexual Penetration of a victim, without their consent.

Sexual and domestic violence

Sexual violence is very common in South Africa, and transgender and gender non-conforming people are at a higher risk because of transphobia, homophobia and social stigma.

Rape occurs when:

- Someone inserts their genital organs into the mouth, anus or genital organs of a victim
- Any part of someone's body, such as a finger, goes into the anus or genital organs of the victim
- Any object, like a stick or a bottle is put into the anus or genital organs of the victim
- The genital organs of an animal are put into the mouth of the victim

If one of your transgender or gender non-conforming patients reports to you that they have been raped, you need to do the following:

GENERAL

1. Under no circumstances may any person be turned away from the facility to seek help from another facility. Do not make judgemental statements or question the rape. Transgender people and sex workers can be raped too.
2. All patients reporting sexual assault or rape are entitled to be interviewed by a trained health worker in a private room. If the person wishes, they can be accompanied by a trusted friend, relative or nurse to support them during the interview. Encourage the survivor not to wash themselves or change their clothes – if they do change they should bring the original clothes with them.
3. If there is a Thuthuzela Care Centre in your area, take the patient to the centre as soon as possible
4. If not, you should offer the following medical services to your patient:
   a. Post-exposure prophylaxis (PEP) for HIV;
   b. Prophylaxis for other sexually transmitted infections;

c. Emergency contraception (if your patient has a vagina and has been raped vaginally)
d. Treatment of injuries
e. Forensic examination.

PROCESS

PEP

5. You must counsel your patient about the potential risks of HIV transmission after rape. The National Antiretroviral Treatment Guidelines set out what this counselling should include. Take into account the information on HIV transmission and risk the HIV chapter of this manual.

6. If your patient presents within 72 hours of being raped, you must offer PEP to prevent potential HIV transmission. PEP must be started as soon as possible, but at the latest within 72 hours after exposure. The National Antiretroviral Treatment Guidelines specify the necessary assessment and treatment. Hormone treatment is NOT a contraindication for PEP (see the chapter on HIV). Before giving PEP, ask your patient whether or not they want to be tested for HIV. If they test negative, give them PEP. If they test positive, don't give them PEP but enrol them in your HIV programme. If they refuse to test, give them PEP for 3 days and ask them to come back in 3 days' time. Do the HIV test then, with the same process as described above.

7. If your patient decides to take PEP, they should be given comprehensive adherence counselling and should be encouraged to return to the clinic for a follow-up appointment. Make sure that the adherence counsellor and follow-up staff are trained to work with trans people.

Consent

8. Before the medical examination, you must provide your patient with sufficient information and disclose of any risk pertaining to the medical examination and procedures.

9. You must obtain informed consent from your patient to conduct the medical examination.

10. You may only collect and release evidence to the SAPS with the informed consent of your patient. If your patient declines the medical examination, the collection of evidence or its release to the SAPS, you need to respect their choice.

Medical Examination

11. You must conduct the medical examination according to the Western Cape Standardised Guidelines for the Management of Survivors of Rape or Sexual Assault and complete the Sexual Assault Examination Crime Kit (SAECK) and the J88 form. The J88 form will be used for the court record in the first instance, and must be given to the SAPS after examination.

Police Reporting

12. You must establish whether your patient has reported the matter to the police.

13. If your patient declines to report the rape to the police, you need to respect this choice and not put pressure on them. If your patient chooses to report the case to the police, you must contact the police station in the area in which the rape or sexual assault occurred and ask for a police officer to come to the health facility to take a statement from the patient. This should only be done after the examination. You should stay for the statement-taking and act as an advocate for your transgender or gender non-conforming patient. Members of SAPS very often don't have much knowledge about transgender and gender non-conforming people. Ensure that your patient knows their rights under the Service Charter for Victims of Crime in SA.

14. If your patient is under the age of 18, special legal provisions are in place through the Sexual Offenses Act and the Children's Act. It is your legal duty to report the sexual assault/ rape to SAPS, regardless of whether or not your patient consents.

After the medical examination

15. Tell your patient about options for counselling services. Make sure that your facility has a list of counselling services available. In this list, include support services specific for transgender and gender non-conforming people (see list of organisations in the resource section of this manual). Be aware of the fact that not all counselling services are knowledgeable of transgender people, and may not be safe spaces for transgender and gender non-conforming people. If you can, speak to the counselling services in your area and educate them about trans issues. If the patient presents with acute stress disorder and/ or other symptoms that warrants psychotherapeutic intervention refer the patient to a clinical psychologist. For social problems refer to a social worker.

Domestic violence is very prevalent in South Africa. It is defined as abusive behaviour in relationships, which takes a variety of forms and includes physical, emotional, psychological, sexual and economic abuse. Domestic violence also happens to transgender and gender non-conforming people, whether they are in lesbian, gay or straight relationships.

Health care providers and people working in NGOs in the health field are often the only people that hear about a person's history of domestic violence (Aschman et al, 2012). You should ask every patient about whether or not they have experienced domestic violence. If a patient reports domestic violence to you, these are guidelines developed by the Institute of Criminology at the University of Cape Town (Martin & Jacobs 2003):

1. All patients who disclose domestic violence must be assessed as soon as

possible using the attached domestic violence examination form.

2. When a person presenting to a clinic discloses domestic abuse or alleges to have been abused or assaulted you should believe them and ensure that they are treated correctly and with dignity.

3. You may not turn a patient away.

4. The Domestic Violence Examination Form (available online, link in the resource section of this manual) constitutes the confidential medical record of the patient. It may however be subpoenaed as a court document if the court deems it necessary. It is essential to record all information and findings accurately, legibly and to remember that the original document could become part of a court record.

5. Complete the Domestic Violence Examination Form. A checklist for documentation is noted below:
   - Document the exact words used by the patient.
   - Do not ask the patient about abuse in the presence of children as they pose a risk to confidentiality.
   - Document the identity of the offender and his relationship to the patient.
   - Record the history of abuse (the presenting complaint of recent abuse, and all incidents of past abuse).
   - Document all symptoms experienced and injuries sustained for present and past abuse.
   - Document all injuries by recording the measurements thereof with a ruler, the exact anatomic location, the nature of injury, the age and any healing that has occurred. Use the body charts for recording a sketch.
   - If possible state that the injury is consistent with the patient.'s account.
   - Take photographs if resources permit.
   - Ensure that all medical records are stored safely, preferably in the Superintendent's office.

6. Remember to label each page with the patient's name and folder number.

7. Establish whether the patient has reported the matter to the police. Explain to them the advantages and disadvantages of reporting the incident mindful of the patient's risk of danger of doing so at this instant. Respect it if your patient chooses not to report.

8. If the patient chooses to report the case to the police, then you must phone the police station in the area in which the domestic violence occurred and ask for a police officer to come to the health facility to take a statement from the patient. Be prepared to act as an advocate for your transgender patient. Police often don't have much knowledge about transgender and gender non-conforming people.

9. If the patient declines to report domestic violence to the police or to undergo a full physical assessment, you need to respect this choice and not put them under pressure.

10. A J88 form must be filled in for all cases where the patient has reported the incident to the police and in instances where the patient indicates that they will lay a charge of assault or where they will seek relief in terms

of the Domestic Violence Act. The J88 form will be used for the court record in the first instance, and must be given to the SAPS after examination.

PLEASE NOTE: Detailed notes made on the J88 form may obviate the need to testify in court at a later date. However, if court testimony is necessary, the detailed notes on the domestic violence screening form will serve as an aide d' memoir to compiling an additional affidavit or testifying from, to complement your J88 notes, that will provide the court with good medical evidence.

11. All domestic violence survivors are to be interviewed by the appropriate health professional in a confidential manner in a private room for appropriate examination and counselling. It is advisable that the spouse/partner or children are not present during the interview.

12. Routine clerking notes of the patient must be kept in the patient's folder, especially special investigations performed, treatment given and follow up appointment dates.

13. Domestic violence survivors should be advised to have an HIV test.

14. Domestic violence survivors should be given the option of going for counselling to a:
    - Social worker
    - Trained counsellor (region specific)
    - Psychologist
    - Domestic violence support service or other local service

Make sure that the referral person knows about transgender and gender non-conforming people and can offer non-discriminatory services to your trans patient.

15. The survivor should be given an updated list of local resources, if it has been established by the health professional that is safe for the patient to do this.

16. The survivor should receive literature on domestic violence to take home and read later, if it has been established by the health professional that is safe for the patient to do this.

17. Domestic violence survivors should be referred to the next level of care when their needs fall beyond the scope or competence of clinic staff. You might consider referring your patient to the transgender service at GSH, or get advice from Gender DynamiX where to find trans-friendly health care providers.

18. If you are subpoenaed to give medical evidence in a domestic violence case, you are strongly advised to consult with the prosecutor and other medico-legal experts before giving testimony in court.

FOR PUBLIC HEALTH CARE	FOR PRIVATE HEALTH CARE	FOR NGOs
Ensure that trans clients are addressed with due respect, using their preferred name and pronouns that correspond to their gender identity	Ensure that trans clients are addressed with due respect, using their preferred name and pronouns that correspond to their gender identity	Ensure that trans clients are addressed with due respect, using their preferred name and pronouns that correspond to their gender identity
In your waiting areas and consultation rooms, provide information booklets for transgender people, put up posters etc.	Design and organize facilities (including bathrooms and inpatient accommodation) in a way that acknowledges the gender identity of transgender and gender non-conforming patients (provide information booklets for transgender people, put up posters etc.) Change the gender identity section of your patient information form to include 'transgender'	Provide information about transgender and gender non-conforming people (booklets, posters).
Educate all your staff about transgender and gender non-conforming people (this includes administrative and cleaning staff)	Educate all your staff about transgender and gender non-conforming people (this includes administrative and cleaning staff)	Educate all your staff about transgender and gender non-conforming people (this includes administrative and cleaning staff)
Be aware of the risk of generalizations and preconceived assumptions about and/or prejudices against transgender and gender non-conforming people	Be aware of the risk of generalizations and preconceived assumptions about and/or prejudices against transgender and gender non-conforming people	Be aware of the risk of generalizations and preconceived assumptions about and/or prejudices against transgender and gender non-conforming people
Ensure that provision of care to transgender and gender non-conforming people is comprehensive and not just limited to HIV/STI care, including all areas related to personal wellbeing	Ensure that provision of care to transgender and gender non-conforming people is comprehensive and not just limited to HIV/STI care, including all areas related to personal wellbeing	Know which services are trans friendly and where you can refer your transgender and gender non-conforming clients to. Be prepared to accompany your clients and act as their advocate should they wish so.
Make sure you stay up to date with recommendations for trans health care. The recommendations listed at the end of this booklet are available online and frequently get updated	Make sure you stay up to date with recommendations for trans health care. The recommendations listed at the end of this booklet are available online and frequently get updated	

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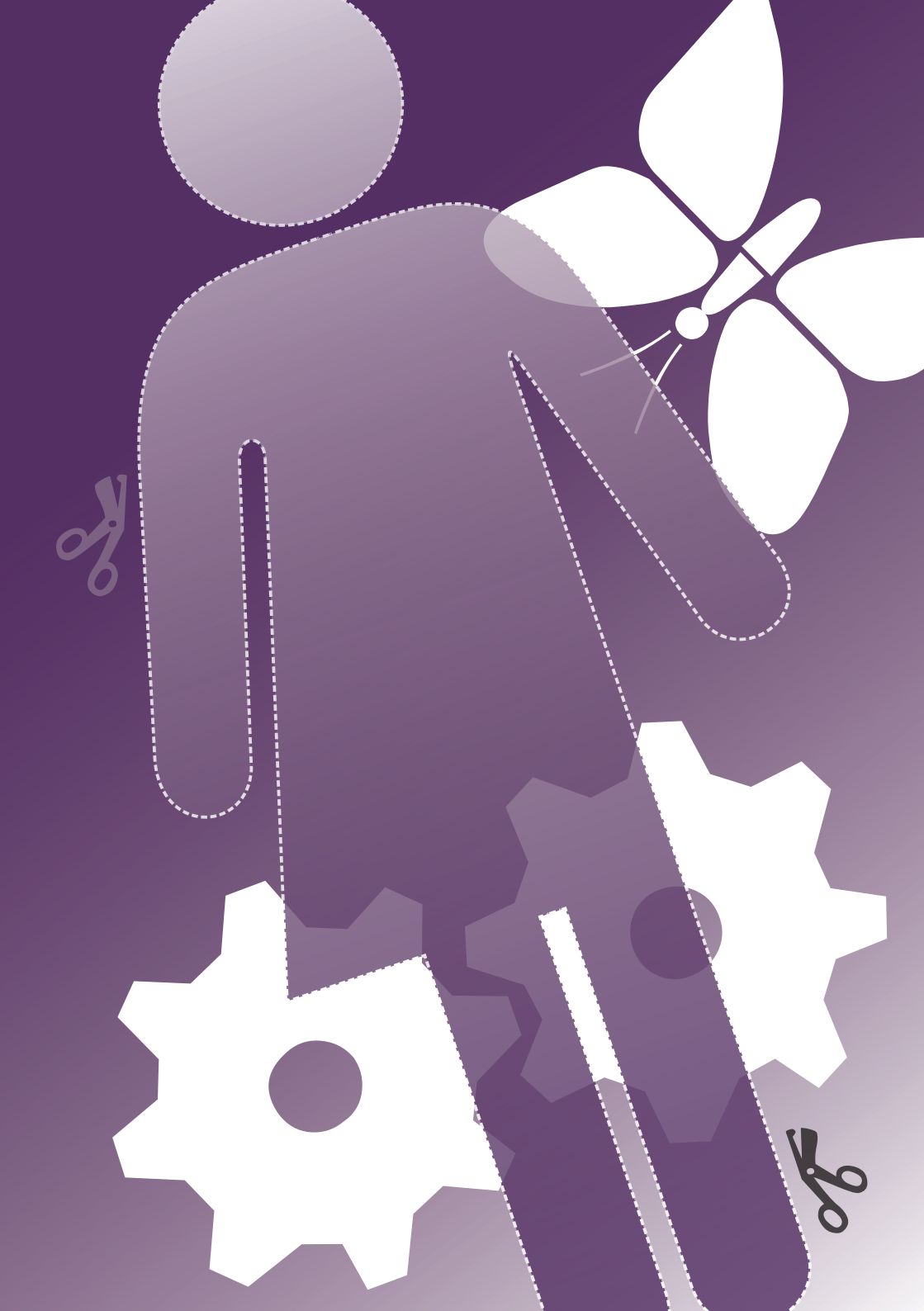

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187 Burger St, Pietermaritzburg 3201

Tel: 033 342 6165

Helpline: 0860 33 33 31

Website: www.gaylesbiankzn.org

Gender DynamiX

Saartjie Baartman Centre,
Klipfontein Road, Manenberg 7764

Tel: 021 633 5287
(Mon-Fri, 9:00-17:00)

email info@genderdynamix.org.za

www.genderdynamix.org.za

Groote Schuur Hospital TG Clinic

Dept of Psychiatry (Outpatients)
Tel: 021 404 2151 Fax: 021 404 2158

Dept of Plastic Surgery
Tel: 021 404 5566

email for referrals/advice:
kevin@academyofplasticsurgery.co.za

General information:
www.academyofplasticsurgery.co.za

S.H.E. *Social, Health and Empowerment feminist collective of transgender and intersex women of Africa*

Office 5, 5th Floor, NBS Building,
Terminus St, East London 5200

Tel: +2773 811 0789

Fax: 086 260 3971

Blog: http://transfeminists.
wordpress.com

Skype: transfeminists

TIA *Transgender and Intersex Africa*

2249 Block F, Soshanguve 0152

Tel: 012 797 2612

Email: transgender.intersex101@
gmail.com

Triangle Project

2nd Floor, Elta House, 3 Caledonian
Road, Mowbray 7700, Cape Town

Tel: +2721 686 1475

Fax: +2721 686 1841

Helpline: 021 712 6699
Daily 1pm-9pm

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PO Box 347 Athlone 7760, Cape Town, South Africa
Tel: 021 633 5287, Fax: 086 614 2298
email: info@genderdynamix.org.za, www.genderdynamix.org.za

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